Core Tasks of Psychotherapy: What Expert Therapists Do

DONALD MEICHENBAUM

This is the fourth time I am presenting at an Evolution of Psychotherapy Conference. Each time I feel honored and privileged to be included with such esteemed psychotherapists from whom I have learned so much and whom I admire. But, I am also challenged, as are the participants in this conference, to determine what distinguishes this group of “experts,” and moreover to determine what they have in common.

I have always been fascinated by the nature of expertise. In fact, my colleague Andrew Biemiller and I have recently written a book on educational expertise entitled, Nurturing Independent Learners, in which we reviewed the literature on expertise (Meichenbaum & Biemiller, 1998). Psychologists have studied experts in such varied areas as sports, artists, writers, computer programmers, jugglers, chess players, waiters, and psychotherapists. What do these various expert groups have in common and what is the relevance to understanding expert psychotherapist?

The research indicates that experts differ from novices and from experienced nonexperts in terms of their:

a) knowledge (know what, how and when to do things, or what have been characterized as declarative, procedural and conditional knowledge);

b) strategies or plans for achieving their goals and their ability to monitor their strategies and performance and alter them accordingly (what is called metacognitive skills);

c) motivation to excell (commitment, interest, persistence, goal-oriented practice).

Now let us apply these constructs of knowledge, strategies, and motivation to the area of psychotherapy. Imagine that you, or a family member or a friend, are in need of a psychotherapist. Who in your area would you turn to for help? Whom would you consider a “therapist’s therapist”, or an “expert”? What does this therapist know and do that warrants your vote of confidence? How has this competent therapist incorporated the findings from the research literature on psychotherapy into his or her clinical repertoire?

Another way to address these questions is to raise the concerns that my tennis instructor highlights during my tennis lessons. She works on simplifying and identifying the “core tasks” of tennis into their component features, viz., ground strokes of forehand or backhand, consisting of top spin, slice, drop shots, volleys, net game and serve. Moreover, she not only helps me master these basic strokes, she also highlights how I need to alter them depending on the strengths and weaknesses of my competitor, the stage and
situation of the match, and the level of my endurance. In the same way, I intend to break the craft (and science) of psychotherapy into its “core tasks”.

My list of component core tasks that are enumerated in Table 1 are derived from three sources. First, the process research on psychotherapy (Garfield, 1980; Lambert, 1992; Orlinsky et al., 1994), and secondly, the evidence for empirically supported treatments (American Psychological Association Reports on Dissemination of Empirically-based Therapies, 1995, 1998; Barlow, et al., 1999; Chambless et al., 1996, 1998; Nathan and Gorman, 1998; and Wilson, 1996). The importance of incorporating findings from empirically-based treatments was underscored by Shandish et al. (1997) who have documented that these empirically-based treatment procedures can be applied to a wide range of clinical populations. They examined 56 treatment studies using meta-analytic procedures and categorized the studies on a continuum from least clinically representative to most clinically representative. They found similar effect sizes evident across all points of the treatment continuum. Thus, any enumeration of “core tasks” must be attuned to the findings of these empirically supported treatment procedures.

The final source for deriving the core tasks comes from 35 years of practicing psychotherapy, supervising and teaching novice and experienced therapists. Space does not permit me to review in detail the basis for each of the enumerated core task. I will, however, describe in general some of the core tasks and ways to achieve them. Throughout the remainder of this Evolution Conference, I will demonstrate how these core tasks can be implemented with such varied clinical populations as patients experiencing mixed anxiety-depression, PTSD, anger-control, and borderline personality disorder. Detailed treatment guidelines of the “how to” features of the core tasks have been made available at the conference bookstore, and a book on “How to become a more expert therapist” is in preparation.
TABLE 1
Core Tasks of Psychotherapy: What Expert Therapists Do

1. Develop a therapeutic alliance.
2. Educate the patient about his/her problems and possible solutions.
3. Help the patient reconceptualize his or her problems in a more hopeful fashion: nurture hope.
4. Ensure that the patient has coping skills.
5. Encourage the patient to perform “personal experiments” in vivo: ensure that the patient takes “data” as evidence to unfreeze their beliefs about self and world.
6. Ensure that the patient takes credit for change: nurture a sense of personal agency/sense of mastery.
7. Conduct relapse prevention.

Additional Psychotherapeutic Tasks for Treating Patients with a History of Ongoing Victimization

8. Address the patient’s basic needs, safety and help him/her develop symptom regulation including any comorbidity features.
9. Address memory work and help the patient retell his/her story, but help the patient to alter his or her belief system and implications.
10. Help the patient find meaning and transform pain.
11. Help the patient reconnect with others who are not “victims”: address impact of trauma and disorder on significant others.
12. Address issues of possible revictimization.

In Search of “Expert” Therapists
The search for the features of “expert” therapists and the common mechanisms of behavior change was given a major impetus by Jerome Frank (1973). This search has
taken varied modern forms as illustrated by the research efforts of Goldfried et al. (1991), Jennings and Skovholt, Stiles et al. (1998), Tharp (1999), and Skovholt et al. (1997). A review of this literature is beyond the scope of this paper. In the enumeration of therapist factors, however, it is important to keep in mind that patient characteristics and relationship factors (bi-directional influences between the therapist and the patient) account for most of the variance in treatment outcome. As Lambert (1992) observes, 30 years of psychotherapy research has demonstrated that the client factors, including their strengths and resources, their social supports, and the environment in which they live, are most important in predicting outcome.

This means that if therapists wish to be successful or if they want to see most improvement in their patients, the most important thing they can do is to choose their patients carefully. They should work with what are called YAVIS patients (e.g., young, attractive, verbal, intelligent and successful). They should stay away from difficult patients who are chronically distressed with comorbid features of psychiatric and physical disorders (e.g., Axis II disorders), who have been or are being repeatedly victimized, and who have multiple problems and who are unmotivated, noncompliant and who live in an environment that undermines treatment. Such difficult patients, however, constitute an increasing majority of patients therapists see. In most instances, therapists cannot choose who they see in therapy, and often they seek the challenge of working with difficult patients.

Well, if therapists cannot choose whom they see in therapy, then what can they do? My answer to this question is the enumeration of the core tasks of psychotherapy. The first seven core tasks are common to all forms of psychotherapy, no matter what the therapeutic approach that is being employed; no matter what the theoretical orientation that is being adapted; and no matter the patient population.

The last five core tasks enumerated in Table 1 derived from working with psychiatric patients who have a history of victimization or who are suffering from PTSD and Complex PTSD. Epidemiological studies indicate that up to 50% of psychiatric patients have a history of victimization, often overlooked by the mental health community. For example, consider that 34% to 53% of patients with severe mental illness report childhood sexual and physical abuse (Meichenbaum, 1995). Meuser et al. (1998) reported that among severely mentally ill patients (schizophrenia and bipolar disorders), 96% report exposure to at least one traumatic event and 43% meet the diagnostic criteria of PTSD, but only 2% had a diagnosis of PTSD in their clinical charts. The expert therapist needs to systematically assess and alter treatment accordingly when a history of or ongoing victimization is evident. The last five core tasks need to be implemented whenever PTSD is a consideration. Let us consider these core tasks of therapy.

1. Develop a Therapeutic Alliance

One of the robust findings in the psychotherapeutic research literature is that the quality of the alliance, as measured in different ways, from different perspectives, and in
different treatment models, is a powerful predictor of treatment outcome (e.g., Horvath & Symonds, 1991). These studies indicate that the quality of the alliance is a function of the agreement between the therapist and the patient regarding the therapeutic tasks and agreement of goals of therapy, as originally suggested by Bordin (1979). In fact, Safran and Muran (2000) have argued that the quality of the therapeutic alliance is more important than the treatment techniques that are employed. Lambert (1992) has highlighted that the quality of the therapist’s interaction, warmth, empathy, ability to establish and maintain a therapeutic alliance, are critical in predicting treatment outcome. Similarly Strupp (1995) observes, “Empathy is the single most important human and technical tool at the therapist’s disposal.”

The importance of the therapeutic alliance is also underscored by the findings that the pattern of patient participation within the first three therapy sessions is predictive of outcome (e.g., patients affective bond, ability to work purposefully in therapy).

2. Educate the Patient

Inherent in all forms of psychotherapy is an effort to educate patients about the nature of their disorders, about the variety of factors that contribute to their problems (i.e., collaboratively co-create a case conceptualization), and about the goals and tasks of psychotherapy. This educational process is not didactic, but Socratic and ongoing. There is also a need to educate patients about their “strengths” or what they have been able to accomplish in spite of their psychiatric disorders and distress. Moreover, an examination of how they have survived and thrived will help nurture the patients’ sense of hope.

The ongoing assessment processes that the therapist employs with patients helps them to become more aware of what they are doing, thinking, and feeling, and how these processes interconnect. Elkin et al. (1999) have also highlighted the value of assessing the patient’s beliefs about the causes of his or her problems and his or her notions about what will be helpful in treatment. The expert therapist can then incorporate and tailor treatment to the patient’s understanding. The more compatible the treatment approach is to the patient’s predilections the greater the likelihood for successful treatment outcome (see Beutler & Clarkin, 1990).

The therapist may use a variety of procedures to conduct such educational efforts. Among others, these include:

- a) convey information as part of social discourse, use written materials;
- b) have patient’s engage in self-monitoring and situational analyses;
- c) use videotape modeling films;
- d) use therapist and group feedback (if treatment is offered in couples, family or group basis).

Also note that therapists provide a rationale for the treatment which frames the intervention and helps motivate patients to change (e.g., use of motivational interviewing).
3. Nurture Hope

A number of theorists have highlighted the role of hope in the change process (Frank, 1973; Kirsch, 1990; Snyder, 1994). In fact, one can look upon the history of psychotherapy, and to some degree the history of medicine, as a testament to the role that hope plays in the healing process. As Shapiro (1960) astutely observes, many forms of medical and psychological treatments that were considered helpful were indeed using ineffective ingredients and inert components. Their effectiveness instead can be attributed to the *placebo effect* or due to the hope they nurtured in their patients and therapists.

Research (reviewed by Snyder, 1994) has indicated that when individuals have hope or hold the perception that something desired may happen or the perception that their goals can be met, then they are more likely to:

a) generate successful plans (“will and ways”) to reach their goals;
b) persist in the face of frustration;
c) produce emotional states that nurture and enhance performance.

The expert therapist helps their patients to believe that tomorrow and the future tomorrows can be different from the todays and the yesterdays. The positive effects of psychotherapy are basically mediated by increases in hope and nurtured by a sense of positive goal-related expectances in their lives.

Space does not permit a detailed discussion of the core tasks of how to teach skills and ensure for the generalization and maintenance of change (Core Task 4), nor a consideration of how to conduct the cognitive restructuring and problem-solving procedures that will ensure that patients perform personal in-vivo experiments so they can collect data that is incompatible with their prior expectations and beliefs (Core Task 5). Inherent in both core tasks 4 and 5 is an evidential model of change, as discussed by Meichenbaum, 1995.

Lambert (1992) has highlighted that patients who attribute change to their own efforts are more likely to maintain such change. The expert therapist ensures that patients “take credit” for improvement. In order to accomplish this core task the therapist may ask the patient such question as:

*You said, “It worked.”*

*What exactly did you do in situation X?*

*Worked? How do you know it worked? What differences did you notice? Who else noticed these differences?*

*How did you handle it this time compared to how you handled the situation in the past?*

*Where else did you do this?*

*Are you telling me, are you saying to yourself, that you could notice, catch, interrupt, use your game plan, had choices, etc. … therapist chooses among these when reflecting?*
What does this mean about you as a person?

Research reviewed by Meichenbaum (1995) indicates that such self-attributional processes also need to be nurtured, even when the improvement results from medication. Insofar as the patient can attribute behavior change to what the medication has allowed him or her to do (as compared to attributing the improvement just to the medication), the improvements are sustained.

In short, it is not just that patients change, but the explanations they offer that is critical to the maintenance of change. Expert therapist do not leave such attributions to chance. They ensure that patients express personal agency and self-efficacy about the change process.

7. Relapse Prevention

In most instances, psychiatric disorders are episodic in nature. For example, in the area of depressive disorders, despite aggressive pharmacological and psychotherapeutic approaches, approximately 15% of patients remain chronically depressed. Fifty percent of individuals who are depressed will experience another episode and the risk of recurrence increases with each episode. After the second episode, the risk is 70% of recurrence; 80% after the third episode; and 90% after the fourth episode (Teasdale, 1999).

In the area of addictions, where the initial interventions using relapse prevention were first employed (Marlatt and Gordon, 1985), the rate of relapse is very high. Sixty percent of those successfully treated revert to their prior behavior patterns within 3 months after therapy, increasing to 60% at 6 months, and 75% at 12 months (Meichenbaum & Turk, 1987).

Another form of concern about relapse arises in the case of anniversary effects for individuals who have experienced traumatic events. The occurrence of reminders can trigger recurrent distress (Meichenbaum, 1995).

Whether it is depression, substance abuse, or PTSD, the expert therapist must help patients to identify high risk situations, notice prodromal warning signs and enhance the patient’s skills for coping with these triggers and situations. An important tasks in therapy is to help patients manage lapses, as well as restructure the patient’s perceptions of the relapse process (see Larimer et al., 1999).

The expert therapist recognizes that major depression and chronic PTSD, both of which often co-occur with other psychiatric disorders, are often lifelong disorders. Following from an initial episode, future relapse and recurrence are the norm. While research has indicated that cognitive-behavioral therapy often produce prophylactic effects or reduction of relapse of approximately 40%, there is still a need to provide ongoing support and to teach skills even for patients who have recovered from recurrent disorders such as depression. A core task is to help patients learn skills to reduce the risk of relapse and to reduce their vulnerability to future lapses. Teasdale (1999) observes that patients must learn to “nip in the bud” any incipient relapse by using their coping skills and come to view lapses, should they occur, as “learning opportunities,” rather
then as occasions to escalate the lapse incident into a complete relapse episode. By helping patients to learn to “notice, catch, interrupt, anticipate, and plan for” such lapses, they can learn to make conscious choices and decisions, rather than go on “automatic pilot” and “time-slide” into old, well-worn, habitual dysfunctional feelings, thoughts and behaviors that led to their initial distress.

The expert therapist recognizes that some patients will need recurrent help or what has been called intermittent brief therapies throughout the life cycle (Cummings, 1986).

Core Tasks 8 through 12 have been designed to be employed with patients who have a history of victimization or who are currently experiencing (re)victimization. The selection of these core tasks was derived from a comprehensive review of the PTSD literature by Meichenbaum (1995). Some of the major illustrative findings underscore the inclusion of these core tasks.

1. The unique features of PTSD (namely, intrusive ideation, avoidance behavior and hyperarousal) require specific interventions. Avoidance behavior has been indicated as being highly correlated with poor treatment outcome and relapse.
2. 98% of patients with PTSD have at least one comorbid disorder. For example, PTSD and substance abuse are strongly linked for women, and thus require an integrated intervention approach that treats both disorders concurrently -- see Najavits et al., 1998.
3. Traumatized individuals who have shared their accounts of victimization with others have a better outcome than those who have not engaged in retelling (Pennebaker, 1990).
4. It is not merely the self-disclosure of trauma, but rather how patients make sense of the impact of the victimization experience that is critical to adjustment (Silver et al., 1983).
5. There is a high incidence of revictimization. For example, up to 50% of rape victims report revictimization (Gold et al., 1999).

Expert therapists need to develop specific interventions that address issues of comorbidity, revictimization, and ways of finding meaning. Meichenbaum (1995) has described the specific ways these core therapeutic tasks can be implemented. A constructive narrative perspective provides a useful framework for helping patients tell their stories in a more hopeful fashion, as they move from being a “victim” to being a “survivor” who can thrive.

Like patients, expert therapists have a story to tell. As we listen to the esteemed therapists tell their stories over the course of the Evolution conference, consider how many of the core tasks of psychotherapy are evident. How do these expert therapists:

a) develop a therapeutic alliance;
b) educate and nurture hope in their patients;
c) teach skills and encourage their patients not only to perform personal experiments, but also to take credit for the changes they brought about;
d) anticipate and cope with possible lapses and possible revictimization;

e) assess for and address the impact of victimization and help patients retell their stories in a more helpful fashion that highlights what they did to survive;

f) help patients fashion meaning and transform their pain with the help of others into a tale of courage and resilience?

References


---

**A Response to Donald Meichenbaum**

*Jay Haley*

I am honored by the invitation to attend this Evolution meeting once again. I particularly am complimented by being given the opportunity to comment on Dr. Meichenbaum’s paper. I hope to make comments worthy of the opportunity, which is difficult with a thoughtful and scholarly paper.

One compliment I would like to make is that while surrounding the text with research reports the core of psychotherapy proves to be commonsense. That has been unusual in the field until recently, particularly among experts. Let me summarize it briefly.

The therapy does best if the client likes the therapist.

The therapist does best if he teaches the client what it’s all about.
If the therapist generates hope the client is more likely to improve. The therapist should prevent relapse. To be successful one should carefully choose patients, preferably YAVIS clients (young, attractive verbal, intelligent and successful). Difficult clients are an increasing majority and can be helped by the 7 core tasks. While it’s a pleasure to find common sense coming into the therapy field, it leaves a discussant with a problem. At this meeting we are, I think, trying to bring therapists together in agreements when possible. We should also differ on some issues to give the audience an awareness of differences. It is a problem critiquing common sense. I will give it a try out of a sense of duty for the meeting. I will not focus only on what is presented in the paper as much as I will also focus on what is not presented. If this paper is the core of therapy, I must do what I can with the remainder of the apple. I will list additional issues that I expect the student therapist to be trained in these days. For example, a therapist should be able to describe a problem in different social units, as in an individual, a dyad, triad, etc. That means one can describe a symptom as an individual problem, for example, an eating disorder where the client cannot restrain her impulses. One can describe the same person as a wife whose husband habitually takes care of her, so she must have a problem to fill the marriage contract. A third possibility is a triad, such as the woman caught between her mother and her husband in conflict over her eating disorder, and she cannot escape the coalition. All of these symptoms are the same woman but different theories. All of them are true. I think we have learned that an explanation is a hypothesis about a symptom which is not necessarily true. It is a commonsense framework for designing a therapy, not that truth we once thought we would find. It seems apparent that this approach involves a theory that includes a marriage and a family unit as the source of a problem. It supplements Dr. Meichenbaum’s paper which does not include anyone whose symptom is a product of a marriage or family. That is the core without the apple.

Let me give an example. A woman was referred for a compulsive disorder. She could not stop washing her hands. She also said she had a problem with her husband who was a tyrant. The husband was in the session, because this problem was defined as a dyad which is often useful with compulsive disorders. The husband said with a sigh that it was true he was a tyrant and insisted on his own way. However, it soon was learned that the wife could not wash the dishes because she could not stop once she started. The husband did the dishes. She could not clean the house because cleaners had poison in them so the husband cleaned the house. As you might guess the wife forced the tyrant husband to be a house slave by just washing her hands. That is a hierarchical explanation of the symptom. Some people argue that there is always hierarchical confusion if there is a symptom. The task is to change a sequence, which changes the individual. This family explanation is a clinical theory which was developed 40 years ago to supplement or replace the individual theory.
Another supplement is an increasing problem these days. When Europeans migrated to this country their problems were dealt with by therapists with a European background. This means that therapy in its beginnings was created on the European unconscious. A student therapist is now likely to be from a different background and he or she and the client is likely to be from Asia or Latin America. We must adapt theory to the change in immigrants in this country.

As an example, a man came into an emergency room acting strangely and agitated. He was an Asian. The staff did not know what was wrong or where he was from because they did not speak his language. Finally they concluded he was Cambodian. They therefore sent for a translator. The translator arrived and proved to be a Vietnamese who hated Cambodians.

Some therapists remember when such problems were unusual. The extent of the mixture can be illustrated. An elementary school near where I lived had an Ethnic day. All the kids came in their native costume. There were one hundred and thirty different ethnic groups. We might expect a number of them will end up in therapy looking for an expert and translator.

Defining expert therapists by Dr. Meichenbaum means therapists who work in a situation where they have control over how they will conduct the therapy. We have traditionally had clients who wanted to be in therapy and therapists who wished to deal with them. In the last decade that has changed. The courts have discovered therapy. They offer clients the choice of going to jail or going into therapy. Some of them choose therapy. The result is a client who doesn’t want to be in therapy and a therapist who does not want to be with a client who does not want to be there. The core of the art of compulsive therapy is forming an alliance with the client who doesn’t want it. The cases have variety, there is sex abuse, drug abuse, spouse abuse, child abuse, adolescent abuse, parent abuse, and whatever other abuses can be defined by the court.

One factor is sometimes overlooked: The therapist does not necessarily control what happens in the therapy in court ordered therapy. Many people can become involved. Recently I had a case with five family members and a therapist assigned to each one, as well as the therapist leading the domestic violence group. With these five therapists there was added four attorneys. The liaison between them was a busy probation officer. The sentences are often fixed, so the individual must be in therapy for six months or a year independent of improvement.

One way to think about the issue of compulsory therapy is that therapists are always the agent of someone. With traditional therapy the therapist was the agent of an individual and would not even talk to a relative on the phone. By the 1960s the therapist was the agent of the family, helping them deal with the system. Now the therapist is the agent of the state by reforming people who are doing what the state wants stopped. It is a question whether that should be the alliance that therapists want.

Therapists deal with ethnic groups of all kinds as well as compulsory therapy with court ordered cases, as well as working with the poor and uneducated who are difficult to reach and teach. Therapists no longer just teach clients who are of the amiable middle class. Now with HMO as the income therapists must see more and more patients to
make a living and many are giving up specializing in a type, like children, or adolescents. The therapists need to know how to do therapy with whoever comes in the door, which makes it hard to be a universal expert.

Let me add one final comment on a way of thinking for a common sense therapist. Dr. Meichenbaum mentions the issue of relapse. It is true that it is a problem and there are different explanations of why and how it happens and what to do. Usually the explanation relates the problem in terms of the individual. Let me offer an interpersonal explanation. Sometimes a client struggles with a problem and then meets a therapist who changes him in brief therapy. Then the client relapses. One explanation is that the client has struggled to get over the symptom and has failed. When the therapist quickly causes change, he or she becomes too powerful. The hierarchical issue arises. The client in some such cases must put the therapist down. One way to do that is to relapse and show that the therapist has not succeeded either. A commonsense explanation? There is also floating out there a commonsense solution. There are two such reasons that I have found and I’m sure out in this audience there are many more. One way is to get out of the responsibility for the cure, for example by the therapist saying the client did it not the therapist, or saying it’s a mystery why it happened (which it often is).

Another procedure is to paradoxically encourage the client to relapse. The client will take power by not relapsing, and both client and therapist win. Dr. Erickson believed there was sometimes a nostalgia for a lost symptom. He handled the problem gracefully by saying to clients that he wants them to go back and experience the symptom as it was, and see if there is anything positive they would like to salvage. Now there was a commonsense therapist.